

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07570

## 7572 CERTIFICATE OF DEATH

Reg. Dist. No. 64

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Caroline</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Caroline</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<b>Federalsburg</b>		<b>50 years</b>		<b>Federalsburg</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>305 Holt Street</b>				<b>305 Holt Street</b>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<b>Frank Scott Bradley</b>				<b>August 12 1955</b>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
<b>Male</b>	<b>White</b>	<b>Married</b>	<b>May 9, 1884</b>	<b>71</b> yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<b>Retired U. S. Postmaster</b>		<b>Postmaster</b>		<b>Wicomico County, Maryland</b>		<b>U.S.A.</b>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<b>John S. Bradley</b>				<b>Amelia (maiden name unknown)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<b>No</b>				<b>None</b>		<b>Mrs. Bessie C. Bradley, Federalsburg, Md.</b>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
154X IMMEDIATE CAUSE						<b>2 wks.</b>	
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <b>Carcinoma of Liver</b>							
DUE TO							
(B) <b>Adeno Carcinoma of Rectum</b>						<b>4 1/2 wks.</b>	
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<b>5/10/51</b>				<b>Adeno Carcinoma of Rectum Grade I</b>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg. etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Aug 12, 1955</b> , 19 <b>55</b> , to <b>Aug 12, 1955</b> , that I last saw the deceased alive on <b>Aug 12, 1955</b> , and that death occurred at <b>11:15 A.M.</b> from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<b>W. K. Knott</b>		<b>Federalsburg, Maryland</b>		<b>Aug. 15, 1955</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Aug. 15, 1955</b>		<b>Hill Crest Cemetery</b>		<b>Federalsburg, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<b>August 15, 1955</b>		<b>Margaret H. Frampton</b>		<b>J.J. Frampton and Son, Federalsburg, Md.</b>			

RECEIVED

AUG 18 1955

BUREAU V. S.

7573

## CERTIFICATE OF DEATH

Reg. Dist. No. 60

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Caroline</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Marydel</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Marydel</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>		STREET ADDRESS (If rural give location) <u>None</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Mamie</u> <u>Burris</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>8</u> <u>1</u> <u>55</u> <u>19</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH: <u>7/16/1904</u>
9. AGE last birthday <u>51</u> Yrs. yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life.) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James Berry</u>		14. MOTHER'S MAIDEN NAME: <u>Emma Green</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Clarence Burris Marydel, Md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Carcinoma of Cervix uteri</u>			
ANTECEDENT CAUSE (B) <u>With metastases to Pelvic</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Organs</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 5, 1955</u> , to <u>Aug. 1, 1955</u> , that I last saw the deceased alive on <u>Aug. 1, 1955</u> , and that death occurred at <u>8:20 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Charles H. Frazier</u>		ADDRESS <u>Freeborn Rd. Aug 3, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8/4/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Price Chaple</u>		LOCATION (City, town, or county) (State) <u>Templeville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>8/4/55</u>		REGISTRAR'S SIGNATURE <u>A. C. Smith</u>	
FUNERAL DIRECTOR <u>J. E. Boule's Funeral Home, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. I.

AUG 22 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07572  
7574  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Caroline</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Caroline</b>
CITY (If outside corporate limits, write RURAL and give nearest town) <b>X</b> TOWN <b>Preston</b>	LENGTH OF STAY (in this place) <b>Life</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Preston</b> <b>X</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00</b>		STREET ADDRESS (If rural give location) <b>/</b>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <b>Mary</b>	(Middle) <b>Ethel</b>	(Last) <b>Fluharty</b>	
(Type or Print)		OF DEATH: <b>August 10 1955</b>	
5. SEX: <b>Female</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH: <b>Sept. 23, 1899</b>
9. AGE last birthday <b>55</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Home</b>	
11. BIRTHPLACE (State or foreign country): <b>Caroline County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Edward Patrick</b>		14. MOTHER'S MAIDEN NAME: <b>Elma Eaton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) <b>No</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-01-7882</b>	
17. INFORMANT & ADDRESS: <b>Arthur S. Fluharty, Preston, Maryland</b>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <b>Carcinoma Head. Pancreas</b>			<b>9-18 '54</b>
ANTECEDENT CAUSE (S) <b>General Metastasis</b>			<b>Jan. 8 '55</b>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
DUE TO (B) <b>General Metastasis</b>			
DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>9-18, 1954</b> , to <b>8-10, 1955</b> , that I last saw the deceased alive on <b>8-10, 1955</b> , and that death occurred at <b>4:55 P.M.</b> , from the causes and on the date stated above.			
SIGNATURE <b>W. E. Simon</b>		ADDRESS <b>Federalsburg, Md.</b>	
		DATE SIGNED <b>Aug. 11, 1955</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Aug. 13, 1955</b>	
NAME OF CEMETERY OR CREMATORY <b>Linchester Cemetery</b>		LOCATION (City, town, or county) (State) <b>Linchester, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>8-13-55</b>		REGISTRAR'S SIGNATURE <b>Cornelia W. Plummer</b>	
24. FUNERAL DIRECTOR <b>J.J. Frampton and Son, Federalsburg, Md.</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 16 1955

RECEIVED



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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07573

## 7575 CERTIFICATE OF DEATH

Reg. Dist. No. \_\_\_\_\_

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X <u>Federalsburg - Rural</u>		<u>Life</u>		X <u>Federalsburg - Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Near Friendship</u>				STREET ADDRESS (If rural give location) <u>Near Friendship</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH:			
(First) <u>Bessie</u> (Middle) <u>Mae</u> (Last) <u>Gadow</u>				(Month) <u>August</u> (Day) <u>18</u> (Year) <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>May 18, 1883</u>	<u>72</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housework</u>		<u>Home</u>		<u>Caroline County, Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John Gootee</u>				<u>Amanda Marine</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>No</u>				<u>None</u>		<u>Herman R. Gadow, Federalsburg, Md., R.F.D.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>420.0</u>							
ANTECEDENT CAUSE (B):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) DUE TO <u>Acute Coronary Occlusion</u>						<u>7 hours</u>	
(B) DUE TO <u>Arteriosclerotic Heart Disease</u>						<u>7 1/2 yrs</u>	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>P. Diabetes Mellitus</u>						<u>P</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/8</u> , 19 <u>55</u> , to <u>8/13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/13</u> , 19 <u>55</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Judy B. Plummer</u>		M. D. <u>Preston, Maryland</u>		DATE SIGNED <u>Aug. 20, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug. 21, 1955</u>		<u>Hill Crest Cemetery</u>		<u>Federalsburg, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Aug 24, 1955</u>		<u>Cornelia B. Plummer</u>		<u>J.J. Frampton and Son, Federalsburg, Md.</u>			

BUREAU V. S.

AUG 23 1955

RECEIVED



7576

## CERTIFICATE OF DEATH

Reg. Dist. No. 61

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Greensboro</u>		8 Yrs.		X TOWN <u>Greensboro</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		None		STREET ADDRESS (If rural give location)		None	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: <u>Laura</u> <u>Hazel</u> <u>Moyer</u>				DATE OF DEATH: <u>8</u> <u>7</u> <u>55</u> <u>19</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Female		White		Married		9/29/1906	
10A. USUAL OCCUPATION (Give kind of work done during most of working life.)		10B. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday		IF UNDER 1 YEAR	
Housewife		None		48 yrs.		Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
Phila., Pa.				U.S.A.			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Wm. H. Saxton				Laura Belle Batters			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:			
No		214-32-1222		Roger Moyer Greensboro, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma of rt. breast</u>						18 mon.	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
Aug. 1954		Carcinoma of rt. breast					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr. 20, 1954</u> to <u>Aug. 7, 1955</u> , that I last saw the deceased alive on <u>Aug. 6, 1955</u> , and that death occurred at <u>12:40 M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles H. Stinner</u>				ADDRESS <u>M. D. Greensboro, Md.</u>		DATE SIGNED <u>8/8/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		8/10/55		Greensboro		Greensboro, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Aug. 10 - 1955		L. M. Pappin		J. E. Boulais		Greensboro, Md.	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 17 1955

BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7577

07575

Reg. Dist. *62*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Caroline</i>	MARYLAND	STATE <i>Ind</i>	COUNTY <i>Cassidy</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town)		CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <i>Denton, Md.</i>	LENGTH OF STAY (in this place) <i>25 years</i>	TOWN <i>Denton</i>	<i>Ind. x</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED: (Type or Print) <i>Bradie Ruth Murphy</i>		4. DATE OF DEATH <i>Aug. 27</i> 19 <i>55</i>	
5. SEX: <i>F.</i>	6. COLOR OR RACE: <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>6/2/1902</i>
		9. AGE last birthday: <i>53</i> yrs.	10. UNDER 1 YEAR: <i>Months</i> <i>Days</i>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>at home</i>		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <i>Denton</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME: <i>Charles Fountain</i>	
14. MOTHER'S MAIDEN NAME: <i>Caranda Griffith</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <i>Harry Murphy (Husband)</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) <i>Hemorrhage - shock</i> DUE TO Antecedent cause(s) (b) <i>Gun shot wound to head</i> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)		<i>Immediate</i>

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:

21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <i>Home</i> )	21c. (City or town) <i>Rural Denton</i> (County) <i>Caroline</i> (State) <i>Ind</i>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>7-2-55 1:45 P.M.</i>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>Gun shot wound to head</i>

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

SIGNATURE *Harold George* CHIEF MEDICAL EXAMINER ☐ DATE SIGNED *8/4/55*  
 DEPUTY MEDICAL EXAMINER ☐  
 ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify): <i>Buried</i>	DATE THEREOF <i>Aug. 5-55</i>	NAME OF CEMETERY OR CREMATORY <i>Concord Cemetery</i>	LOCATION (City, town, or county) <i>Denton, Md.</i> (State) <i>Ind.</i>
DATE REC'D BY LOCAL REG. <i>8/4/55</i>	REGISTRAR'S SIGNATURE <i>Harold George</i>	24. FUNERAL DIRECTOR <i>J. Edgar Moore &amp; Son</i> ADDRESS <i>Denton</i>	



7573

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07576  
Reg. Dist.

No. 62

1. PLACE OF DEATH COUNTY <u>Caroline</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Denton</u> <input checked="" type="checkbox"/> TOWN <u>Denton</u> <u>3 weeks</u> INSTITUTION OR STREET ADDRESS <u>301 High Street</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Delaware</u> COUNTY <u>Kent</u> CITY (If outside corporate limits write RURAL and give nearest town) <u>Harrington</u> <u>46 x</u> TOWN <u>Harrington</u> STREET ADDRESS (If rural, give location) <u>23 Mississippi Street</u> ✓	
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>Charles</u> <u>Smith</u> <u>Postler</u> (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug</u> <u>9</u> <u>1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Aug 8 - 1915</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Housework</u>	9. AGE last birthday: <u>73</u> yrs. <u>0</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.
11. BIRTHPLACE (State or foreign country): <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>Delaware</u>	
13. FATHER'S NAME: <u>John Smith</u>		14. MOTHER'S MAIDEN NAME: <u>Laura Benson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No.: <u>—</u>	
17. INFORMANT & ADDRESS: <u>Roland Postler, 126 W. Milby St, Harrington, Del.</u>			

18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>422.2</u> Immediate cause (a) <u>Myocardial Chronic</u> DUE TO Antecedent cause(s) (b) <u>—</u> Diseases or conditions, if any, giving rise to the above cause, stating underlying cause last (c) <u>—</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u>			
19a. DATE OF OPERATION: <u>—</u>		19b. MAJOR FINDING OF OPERATION: <u>—</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		21. HOW DID INJURY OCCUR? <u>—</u>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY) <u>—</u>	
21c. (City or town) (County) (State) <u>—</u>		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u>	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>—</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>Lawson O George</u> M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>8/9/55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <u>—</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>8-12-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Union</u>		LOCATION (City, town, or county) (State) <u>Frederica, Del.</u>	
DATE REC'D BY LOCAL REG. <u>8/12/55</u>		REGISTRAR'S SIGNATURE <u>Wm O George</u>	
24. FUNERAL DIRECTOR <u>—</u>		ADDRESS <u>—</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AUG

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 62

7579

07577

1. PLACE OF DEATH: COUNTY <u>CAROLINE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY <u>CAROLINE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>DENTON</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Denton</u> <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>567 HIGH ST</u>		STREET ADDRESS (If rural give location) <u>/</u>	
3. NAME OF DECEASED (First) <u>LEONARD</u> (Middle) <u>ALFRED</u> (Last) <u>RICH</u>		4. DATE OF DEATH (Month) <u>AUG.</u> (Day) <u>15</u> (Year) <u>1955</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>JULY 22, 1911</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LUMBER YARD LABOR</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>44</u> yrs. If under 1 year: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM RICH</u>		14. MOTHER'S MAIDEN NAME <u>JULIA EMORY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>0</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>216-14-9150</u>	
17. INFORMANT <u>MOTHER</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>PULMONARY FAILURE</u>		
(b) Antecedent cause(s) <u>TUBERCULOSIS</u>		
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION <u>0</u>	19b. MAJOR FINDINGS OF OPERATION <u>0</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>0</u>	PLACE (Home, farm, factory, street, office hldg., etc.) <u>0</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>0</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>0</u>

22. I hereby certify that I attended the deceased from DID NOT ATTEND to OWN PAY, that I last saw the deceased alive on SICILIAN, 19 NOT AVAILABLE, and that death occurred at NOT AVAILABLE from the causes and on the date stated above.

SIGNATURE <u>Edwin B. Riley</u> M.D. ADDRESS <u>Denton, Md.</u> DATE SIGNED <u>AUG 16 1955</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u> DATE <u>Aug 20, 55</u> NAME OF CEMETERY OR CREMATORY <u>Spring Brook Burial</u> LOCATION (City, town, or county) <u>Denton</u> (State) <u>Ind.</u>	24. FUNERAL DIRECTOR <u>J. Virgil Moore</u> ADDRESS <u>Sawyer</u>
DATE RECD BY LOCAL REG. <u>8/20/55</u> REGISTRAR'S SIGNATURE <u>J. Virgil Moore</u>	

Death occurred at home

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. This certificate is especially important. Physicians: please write the cause of death clearly and legibly.

BUREAU V. S.



7580

## CERTIFICATE OF DEATH

Reg. Dist. No. 60 ...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Caroline</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Caroline</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Goldsboro</u>	LENGTH OF STAY (in this place) <u>8 Yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Goldsboro</u>	<u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>		STREET ADDRESS (If rural give location) <u>None</u>	<u>1</u>
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Carl</u>	(Middle) <u>W.</u>	(Last) <u>Schneider</u>	OF DEATH: <u>8</u> <u>14</u> <u>55</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <u>9/14/1893</u>
9. AGE last birthday: <u>61</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farm Owner</u>	11. BIRTHPLACE (State or foreign country): <u>Germany</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>Peter Schneider</u>		14. MOTHER'S MAIDEN NAME: <u>Louise Schmidt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-32-8780</u>	
17. INFORMANT & ADDRESS: <u>Alfreda Schneider Goldsboro, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Bronchio-genic Carcinoma</u>		<u>4 mos.</u>
ANTECEDENT CAUSE (B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19A. DATE OF OPERATION: <u>Jan 14, 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Bronchio-genic Carcinoma</u>
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
(IF EITHER, NOTIFY MEDICAL EXAMINER)		

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from May 20, 1955, to Aug. 14, 1955, that I last saw the deceased alive on Aug. 14, 1955, and that death occurred at 1:50 P.M. from the causes and on the date stated above.

SIGNATURE <u>Clark H. Fries</u>	ADDRESS <u>Goldsboro, Md.</u>	DATE SIGNED <u>Aug 16, 1955</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>8/17/55</u>	NAME OF CEMETERY OR CREMATORY <u>Denton</u>
LOCATION (City, town, or county) (State) <u>Denton, Maryland</u>		

DATE REC'D BY LOCAL REGISTRAR <u>8/17/55</u>	REGISTRAR'S SIGNATURE <u>Clark H. Fries</u>	FINANCIAL DIRECTOR <u>J. E. Boulain</u>	ADDRESS <u>Goldsboro, Md.</u>
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MARGIN RESERVED FOR BINDING

BUREAU V. S.

JUL 1955

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07580  
7581 CERTIFICATE OF DEATH

Reg. Dist. No. 64

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural- Seaford, Del. R. F. D. 15 Yrs.</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural- Seaford, Del. R. F. D. X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Near Reliance</u>				STREET ADDRESS (If rural give location) <u>Near Reliance</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Marion Harry Tull</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>Aug. 21 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 5, 1887</u>	9. AGE last birthday <u>68 yrs.</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>16</u>	IF UNDER 24 HRS. Hours <u>16</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Dorchester County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Lewis W. Tull</u>				14. MOTHER'S MAIDEN NAME: <u>Mary E. Butler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-61-1019</u>		17. INFORMANT & ADDRESS: <u>Mrs. Nora H. Tull, Seaford, Del. R. F. D.</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>177X Carcinoma of Prostate</u>				<u>3 years</u>			
ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST				OUE TO <u>Gland with adenocarcinoma - skeletal metastases</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>DEC 3, 1951</u> , to <u>AUG 21, 1955</u> , that I last saw the deceased alive on <u>AUG 21, 1955</u> , and that death occurred at <u>5:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>R. H. [Signature]</u>		ADDRESS <u>M. O. [Signature]</u>		DATE SIGNED <u>8/22/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>August 24, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Cokesbury C emetery</u>		LOCATION (City, town, or county) (State) <u>Near Federalsburg Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>August 23, 1955</u>		REGISTRAR'S SIGNATURE <u>Margaret H. Frampton</u>		24. FUNERAL DIRECTOR <u>J. J. Frampton and Son, Federalsburg, Md.</u>			





7582

## CERTIFICATE OF DEATH

Reg. Dist. No. 64

## 1. PLACE OF DEATH:

COUNTY Caroline

MARYLAND

CITY (If outside corporate limits, write RURAL, and give nearest town)

X TOWN Federalsburg - Rural

LENGTH OF STAY (in this place)

4 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS

00 Near A merican Corner

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Caroline

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN Federalsburg - Rural X

STREET ADDRESS (If rural give location)

Near American Corner

## 3. NAME OF DECEASED:

(First)

Susie

(Middle)

Elizabeth

(Last)

Wade

## 4. DATE (Month)

(Day)

(Year)

OF DEATH:

August 291955

## 5. SEX:

Female

## 6. COLOR OR RACE:

Colored

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Married

## 8. DATE OF BIRTH:

September 9, 1919

## 9. AGE last birthday

35

## IF UNDER 1 YEAR

## IF UNDER 24 HRS.

Months Days Hours Min.

## 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

Housework

## 10B. KIND OF BUSINESS OR INDUSTRY:

Home

## 11. BIRTHPLACE (State or foreign country):

Jacksonville, Florida

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME:

Lorenza W. Slaymon

## 14. MOTHER'S MAIDEN NAME:

Joanna Jones

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

## 16. SOCIAL SECURITY NO.

266-46-3482

## 17. INFORMANT &amp; ADDRESS:

Nathaniel Wade, Federalsburg, Md., R.F.D

## 18. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

171X

## IMMEDIATE CAUSE

(A)

Intestinal obstruction (colostomy)

## INTERVAL BETWEEN ONSET AND DEATH

2 months

## ANTECEDENT CAUSE (B)

DUE TO

(B)

metastatic carcinoma of intestine1 year

## DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO

(C)

Carcinoma of cervix2 years

## II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION:

July 12, 1955

## 19B. MAJOR FINDINGS OF OPERATION

Metastatic carcinoma of intestine & obstruction

## 20. AUTOPSY?

YES ☐ NO ☒

## 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)

## 21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

## 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

M.

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

## 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-3, 1955 to 8-21, 1955, that I last saw the deceased

alive on

SIGNATURE

Robert C. Kingsbury

M.D.

ADDRESS

Federalsburg, Maryland

DATE SIGNED

Aug. 29, 1955

## 23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

## DATE THEREOF

Aug. 31, 1955

## NAME OF CEMETERY OR CREMATORY

Liberty Chapel Cemetery

## LOCATION (City, town, or county)

Reddick, Florida

(State)

## DATE REC'D BY LOCAL REGISTRAR

August 31, 1955

## REGISTRAR'S SIGNATURE

Margaret H. Frampton

## 24. FUNERAL DIRECTOR

J.J. Frampton and Son, Federalsburg, Md.

## ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 8 1905

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07583

7583

## CERTIFICATE OF DEATH

Reg. Dist. No 62

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Caroline</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Caroline</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X <b>Denton - Rural</b>		<b>50 years</b>		X <b>Denton - Rural</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Near Howard's School</b>				STREET ADDRESS (If rural give location) <b>Near Howard's School</b>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) (Middle) (Last) <b>Jacob Zierl</b>				<b>August 2 1955</b>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<b>Male</b>	<b>White</b>	<b>Married</b>	<b>Sept. 15, 1895</b>	<b>59</b> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Farmer</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Farm Owner</b>		11. BIRTHPLACE (State or foreign country): <b>New York City</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Jacob Zierl</b>				14. MOTHER'S MAIDEN NAME: <b>Bertha (maiden name unknown)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-09-1474</b>		17. INFORMANT & ADDRESS: <b>Mary D. Zierl, Denton, Maryland, R.F.D.</b>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>151X Carcinoma Stomach</b>							<b>2 years</b>
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <b>April 1954</b>		19B. MAJOR FINDINGS OF OPERATION: <b>Carcinoma Stomach</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>May</b> , 1955, to <b>Aug 2</b> , 1955, that I last saw the deceased alive on <b>Aug. 2</b> , 1955, and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>E. Paulthorpe</b>		ADDRESS <b>Denton Md</b>		DATE SIGNED <b>8-6-55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Aug. 5, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>		LOCATION (City, town, or county) (State) <b>Federalsburg, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>8-5-55</b>		REGISTRAR'S SIGNATURE <b>W. D. O. George</b>		24. FUNERAL DIRECTOR ADDRESS <b>J.J. Frampton and Son, Federalsburg, Md.</b>			

BUREAU Y. S.

AUG 12 1955

RECEIVED